Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Congenital Heart Disease Genetic Testing Patient Information

Instructions: Accurate interpretation and reporting of genetic results is contingent upon the reason for testing, clinical information, ethnic background/ancestry, and family history. To help provide the best possible service, supply the information requested below and **send paperwork with the specimen, or return by fax to Mayo Clinic Laboratories, Attn: Molecular Technologies Laboratory Genetic Counselors at 507-284-1759. Phone: 800-533-1759 / International clients: +1-507-266-5700 or email MLIINT@mayo.edu**

Patient Information

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*

Sex Assigned at Birth	Legal/Administrative Sex
☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	☐ Male ☐ Female ☐ Nonbinary

Referring Provider Information

Referring Provider Name *(Last, First)*	Phone	Fax*
Other Contact Name *(Last, First)*	**Phone**	**Fax***

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Reason for Testing

☐ Diagnosis ☐ Prenatal ☐ Family History** ☐ Other, specify:

**Genetic testing should be performed on an affected family member first, when possible. FMTT / Familial Mutation Targeted Testing should be ordered when there is a previous positive genetic test result in the family.

Clinical History

Indicate whether the following are present. Check all that apply.

Has the patient had a microarray? ☐ Yes ☐ No
If "Yes," attach results.

Anomalous pulmonary venous return (APVR)
- ☐ Total anomalous pulmonary return (APVR)
- ☐ Partial anomalous pulmonary return (TAPVR)

Atrioventricular Septal Defect (AVSD)
- ☐ Primum atrial septal defect (ASD)
- ☐ Inlet ventricular septal defect (VSD)
- ☐ Complete AVSD/complete atrioventricular (AV) canal defect
- ☐ AVSD + outflow tract obstruction

Complex
- ☐ Multiple complex heart anomalies
- ☐ Complex single ventricle defects
- ☐ Levo-transposition of the great arteries (L-TGA)

Conotruncal
- ☐ Double outlet right ventricle (DORV)
- ☐ Truncus arteriosus (TA)
- ☐ Interrupted aortic arch (IAA)
- ☐ Interrupted aortic arch type B (IAA-B)
- ☐ Dextro-transposition of the great arteries (D-TGA)
- ☐ Tetralogy of Fallot (TOF)
- ☐ Mitral valve atresia (MA)
- ☐ Shone's complex

Left ventricular outflow tract obstruction (LVOTO)
- ☐ Bicuspid aortic valve (BAV)
- ☐ Hypoplastic left heart syndrome (HLHS)
- ☐ Aortic stenosis (AS (+/- CoA))
- ☐ Coarctation of the aorta (CoA) (+/- ventricular septal defect (VSD)

Right ventricular outflow tract obstruction (RVOTO)
- ☐ Pulmonary atresia (PA) (+/- VSD)
- ☐ Pulmonary valve stenosis (PVS) (+/- ASD or any noninlet VSD)
- ☐ Ebstein anomaly
- ☐ Tricuspid atresia

Septal
- ☐ Ventricular septal defect (VSD) (nonspecific)
- ☐ VSD (perimembranous, muscular, or noninlet)
- ☐ Secundum atrial septal defect (ASD)
- ☐ Multiple co-occurring ASD or VSD

☐ Other, indicate:

Congenital Heart Disease Genetic Testing Patient Information (continued)

Patient Name *(Last, First, Middle)*	Birth Date *(mm-dd-yyyy)*

Family History

Are there similarly affected relatives? ☐ Yes ☐ No

If "Yes," indicate relationship and symptoms:

Have any family member had genetic testing? ☐ Yes*** ☐ No ☐ Unknown

*****FMTT / Familial Mutation Targeted Testing should be ordered when there is a previous positive genetic test result in the family. Contact the lab for ordering assistance.**

History of consanguinity: ☐ No ☐ Yes; relationship details:

Ancestry

☐ African/African American	☐ East Asian	☐ Latinx/Latine	☐ South Asian	☐ Unknown
☐ Ashkenazi Jewish	☐ European	☐ Middle Eastern	☐ None of the above	☐ Choose not to disclose

New York State Patients: Informed Consent for Genetic Testing is required. See Informed Consent for Genetic Testing (T576) or Informed Consent for Genetic Testing – Spanish (T826).

Print